



# NNSA Columbia Accident Investigation Board (CAIB) Lessons Learned Review

Brig Gen Ron Haeckel

Lab Ops Board

30 Mar 04



## Resentation Outline



- Tasking and Approach
- Management and Safety Culture
- Corporate Organization
- Technical Capability
- The Way Ahead

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- Ambassador Brooks' letter (9 Sep 03)
  - Is NNSA's management and safety culture appropriate for managing high technology, high-risk activities?
  - Are there issues raised by the CAIB report that should be considered as we implement NNSA's new organizational model?
  - Will the re-engineered NNSA provide for necessary technical capabilities?
  - What changes should NNSA adopt in light of the CAIB report?
- Final report forwarded to NNSA Administrator on 20 Feb 04
- Leadership Coalition discussed implementation 25-26 Mar 04





- Central NNSA team of HQ and Site representatives and 3 Sub-teams
  - Management and Safety Culture
  - Corporate Organization
  - Technical Capability
- Reviewed CAIB Report
- Identified NASA issues relevant to NNSA
- Developed NNSA lessons learned and recommendations



### Review Team



#### **Team Chair**

Brig Gen Ron Haeckel

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#### **Support Members**

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## Management and Safety Culture



#### Lessons Learned

- Oversimplification of technical information could mislead decision-making
- Proving operations are safe instead of unsafe
- Management must guard against being conditioned by success
- Willingness to accept criticism and diversity of views is essential

#### Recommendations

- Re-evaluate decision-maker qualifications and technical development for key decision-makers and encourage continued technical growth of key NNSA decision-makers.
- Communicate the cultural and organizational lessons learned for NNSA from the NASA CAIB report.
- Change the safety behavior of NNSA to be more open to alternate views and minority opinions.
- Develop and publish a safety culture policy statement that clearly defines NNSA's commitment and expectations regarding the role of safety within NNSA.
- Hold periodic safety forums to discuss, as a minimum, trends, issues, lessons learned and best practices from both internal and external sources.



# Corporate Organization



#### Lessons Learned

- Effective centralized and de-centralized operations require an independent, robust safety and technical requirements management capability
- Assuring safety requires a careful balance of organizational efficiency, redundancy and oversight
- Effective communications along with clear roles and responsibilities are essential to a successful organization

#### Recommendations

- Establish a Chief of Defense Nuclear Safety (in lieu of ES&H Advisor).
- Elevate the management and oversight of operational and infrastructure issues.
- Until the NNSA oversight model is defined and LO/CAS is fully implemented and evaluated as effective, NNSA consider reinstating on-site reviews of Site Office oversight systems.
- Headquarters must provide clear guidance as necessary to Site Managers with respect to delegated safety authorities.

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# Technical Capability



#### Lessons Learned

- Workforce reductions, outsourcing, and loss of organizational prestige for safety professionals can cause an erosion of technical capability
- Technical capability to track known problems and manage them to resolution is essential
- Technical training program attributes must support potential high consequence operations

#### Recommendations

- Map out expectations of the Service Center for the next year or two.
- Consider conducting an integrated NNSA Staffing Study and use the results to validate individual staffing plans.
- The NNSA Service Center should employ sufficient technical resources, including support service contractors, to fill peak demand in support of Site Office and Headquarters requirements.
- Provide the necessary resources and priority for continued technical growth of ES&H staff throughout their careers through additional academic training, rotations, and detail assignments within NNSA.



## The Way Ahead



- As a near-term action, Site Offices and contractors should formally submit to the Administrator their Lessons Learned reports from the CAIB review applicable to their operations.
- Naval Reactors safety methods/culture and NNSA relationship with DoD deserve follow-on review.
- Consider establishing an enterprise-wide team to examine the collective lessons learned, integrate the results, and develop complex-wide (Site generic and enterprise-wide) recommendations for action.
- Develop an implementation plan to disposition and address recommendations.